Wyoming Department of Health

Commit to your health.

REFERRAL TO THE
SEVERE MALOCCLUSION PROGRAM
STATE OF WYOMING
DENTAL HEALTH PROGRAM

Please note: This program is for children 12 through 18 years of age.
This form must be completed by the child's dentist.

I would like to refer _____
for an orthodontic examination and diagnostic records.

Date of Birth _____ (**note: program is for ages 12 through 18**)

Parent/Legal Guardian _____

_____

Address City State Zip Phone

Comments: _____

_____

_____

_____

Dentist Signature_____

Dentist Printed Name_____ Date _____

Address_____

This referral must be accompanied with the Severe Malocclusion Program application. **No referral will be accepted without an application.** Applications are available from the Public Health Nursing Office or our website at http://health.wyo.gov. Send the completed application and this referral to:

Wyoming Department of Health
Oral Health Program
6101 Yellowstone Road, Suite 420
Cheyenne, WY 82002